![NACDS - National Association of Chain Drug Stores]

Alternative and Innovative Approaches to Prescription Drug Health Care Delivery under Virginia Medical Assistance

August 2006

Medicaid Revitalization Committee
Department of Medical Assistance Services
600 East Broad Street
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Members of the Medicaid Revitalization Committee:

Thank you for allowing the National Association of Chain Drug Stores (NACDS) to suggest alternative and innovative approaches to prescription drug health care delivery under the Virginia Medical Assistance Program.

NACDS represents the nation's leading retail chain pharmacies and suppliers, helping them better meet the changing needs of their patients and customers. Our members operate more than 35,000 pharmacies, employ 108,000 pharmacists, fill more than 2.3 billion prescriptions yearly, and have annual sales of over $700 billion. In Virginia, NACDS represents 19 chain pharmacy companies with almost 1,000 retail pharmacies, employing almost 101,500 employees, including more than 2,800 pharmacists. NACDS companies pay over $957 million in total taxes to the state of Virginia annually.

Real Medicaid Reform Requires Targeted Solutions

For Medicaid Reform to produce greater efficiency, quality of care, and lasting savings in the delivery of prescription drugs, it must employ targeted solutions. Medicaid must adopt new incentives for providers to implement more flexible and more effective disease management and chronic care programs, particularly for these aged beneficiaries and beneficiaries with disabilities and chronic illnesses. Efforts to better coordinate care should be supplemented with technologies that allow for more efficient methods of collecting and sharing information. New technologies can improve safety and quality in patient care by helping to coordinate care and avoiding duplication of services.

By federal law, all state Medicaid programs are required to have drug utilization review (DUR) programs. These include prospective programs that screen for such issues as drug-drug interaction and drug allergies, as well as retrospective programs that review claims data to identify fraud, abuse, or physician prescribing patterns that reveal inappropriate or medically unnecessary treatments. States should strengthen their Medicaid drug utilization review (DUR) programs by requiring interventions intended to encourage appropriate, safe, and cost-effective prescription drug use. Generally, DUR programs should observe patterns of drug use and costs, compare the results to peer-reviewed standards, and provide information to physicians, pharmacists, or health plan sponsors with the goals of correcting drug utilization problems and minimizing the likelihood of adverse patient health outcomes.

Many Medicaid beneficiaries take five or more drugs each month. When multiple drugs therapies are prescribed, the risks of adverse drug reactions and interactions increase exponentially. DUR programs can help to identify high-end users of prescription drugs, providing opportunities for intervention with the prescribing physicians or the patients themselves. A focus on high-cost users, especially those prescribed many different drugs (poly-pharmacy), has the potential for producing both cost savings and quality improvement.

In particular, physician profiling programs identify doctors whose prescribing practices vary dramatically from their peers or show drug-specific variations, such as when a physician regularly prescribes a brand name version of an off-patent drug where the off-patent drug is more

often prescribed by other physicians. Physician profiles also may identify how well individual physicians adhere to treatment guidelines and preferred drug lists.

Finally, it is important to build upon existing state initiatives in addressing Medicaid reform. The solutions that we recommend to the Department of Medical Assistance Services – medication therapy management, pharmacy-assisted collaborative disease management, and the use of e-technologies – are well-tested in Medicaid and other public and private drug benefit programs and have been shown to produce significant savings. Successful adoption of these initiatives will ensure that Virginia Medicaid beneficiaries receive high-quality, safe, and effective drug benefits at lower costs, a wining combination for reform.

Proposal 1: Expand Use of Medication Therapy Management and Collaborative Pharmacy-Assisted Disease Management in Medicaid Programs

Better management of care – including pharmacy benefits –improves quality of care and patient safety and presents the potential for considerable savings.

Medication therapy management and face-to-face disease management programs focus interventions on helping patients with complex, chronic, and costly medical conditions (such as diabetes, asthma, and smoking cessation) to better understand how to manage their drug therapies and diseases or conditions. Those patients most at risk for medication errors and adverse reactions can be identified and their therapy managed by a pharmacist working with the primary care provider.

Disease management programs typically focus interventions on patients with complex chronic medical conditions, especially those with a high risk of complications and co-morbidities such as diabetes and asthma. There are at least 30 states, including Virginia, with existing Medicaid disease management programs. In addition, over half of private employers with employee health plans report that they offer disease management to their employees.

These programs, such as Virginia's, tend to be broader in scope, focusing on management of the full range of treatments for these patients. Disease management programs may employ or contract with physicians or specialists, nurses or nurse practitioners, or pharmacists in guiding patients to manage their diseases. However, these providers may be located in other states, and disease management services may be provided by phone, rather than face-to-face.

Medication therapy management (MTM), on the other hand, is more targeted, and is primarily intended to optimize health outcomes by helping patients better understand their drug therapies and improve adherence to prescribed regimens using existing pharmacy providers. MTM gained widespread public attention when Congress mandated that it be offered as a service by plans participating in the new Medicare Part D benefit.

Over the last decade, several states have implemented MTM programs and pharmacy-assisted disease management programs for Medicaid beneficiaries. These programs typically focus interventions on patients with complex chronic medical conditions, especially those with a high risk of complications and co-morbidities, such as diabetes, kidney disease, asthma and other chronic pulmonary diseases, or chronic heart disease. They also take a collaborative approach, with the pharmacist and primary care provider working closely and meeting face-to-face with the patient to ensure that medications prescribed are appropriate to the disease or conditions being treated, and do not create additional health issues via adverse reactions or drug interactions. These programs manage not only the patient's disease or condition, but also the medications used to treat the disease or condition. They have a notable track record for achieving significant savings.

Given that Part D requires MTM for high-use, high-cost Medicare beneficiaries using multiple medications – including many dual eligibles that will still be covered by Medicaid for other services such as long-term care – a logical extension would be to apply the same MTM requirements to high-use, high-cost beneficiaries on multiple medications who remain in Medicaid. One could even argue that the anti-discrimination provisions of the Medicaid law imply that non-dual Medicaid beneficiaries should be able to access the same MTM or pharmacy-assisted disease management services available to duals.

Virginia Healthy Returns: In June 2004, the Virginia Medicaid program implemented a pharmacy-assisted disease management program using pharmacists and nurse consultants as program advisors for beneficiaries with just two disease states – coronary artery disease and congestive heart failure. A 10-month review published in September 2005[1] reported improved results in 9 of 12 clinical outcomes, including reduced LDL and blood pressure levels. The report indicated that self-care practices – including blood pressure control, weight monitoring, and adherence to a sodium-restricted diet – had improved and, as a result, the rates of use of ACE inhibitors and beta blockers had declined. There was also a decline in rate of use observed for quinolones, non-sedative barbiturates, analgesics, and antihistamines. The number of inpatient hospital admissions among participants was down 5 percent, as was the duration of admissions.

Overall expense per beneficiary per month had dropped by $23, which led to a two percent gross savings for the Healthy Returns program. This savings was driven primarily by the $17 per beneficiary per month decline in overall pharmacy expenses.

Clearly, the state's positive experience with the Healthy Returns program would justify the expansion of that program to address additional disease states and conditions.

Other Examples of State Medicaid MTM Programs

Medicaid MTM and pharmacy-assisted disease management programs in Mississippi, Iowa, and Missouri also have proved successful in managing costs. These programs pay pharmacy

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[1] *Healthy Returns Care Management Program: Annual Report*, Commonwealth of Virginia Department of Medical Assistance Services, September 2005,

providers on a per-encounter basis for the additional services provided to enrollees. A third program was implemented in Minnesota in April of this year. A fourth program, implemented in North Carolina in June, is reimbursing participating pharmacies on a monthly basis.[2]

Mississippi Medicaid: Mississippi was the first state in the nation in 1998 to receive federal approval to provide reimbursements for pharmacists for MTM encounters. Under the Mississippi program, pharmacists evaluate patients, review drug therapies with doctors, and educate patients about managing the disease and adhering to the drug regimen. Pharmacists are authorized to make up to 12 visits per patient per year, offering counseling and drug therapy management relating to asthma, diabetes, anticoagulation, and hyperlipidemia.

Iowa Medicaid Pharmaceutical Case Management Program: The Institute for the Advancement of Community Pharmacy worked with the Iowa Medicaid program in 2000 in implementing the Iowa Medicaid Pharmaceutical Case Management (PCM) Program, after funds were appropriated by the state legislature. Services under the Iowa program are provided by pharmacist-physician collaborative teams.

Medicaid enrollees are eligible to participate if they take four or more regularly scheduled non-topical medications, are not nursing home residents, and have at least one of twelve select disease states (congestive heart failure, ischemic heart disease, diabetes mellitus, hypertension, hyperlipidemia, asthma, depression, atrial fibrillation, osteoarthritis, gastroesophageal reflux disease, peptic ulcer disease, and chronic obstructive pulmonary disease.) Participating providers receive lists of eligible patients being treated in their practices. Pharmacists also may contact patients to urge them to participate, or may contact patients' physicians to discuss pharmaceutical case management.

In its first year, 117 pharmacies from all areas of the state participated, meeting with 943 (31 percent) of the 3,037 patients deemed eligible for the program. Pharmacists detected an average of 2.6 medication-related problems per patient, recommending a new medication 52% of the time and discontinuation of a medication 33% of the time. Patients receiving PCM services had a 12.5% improvement in the Medication Appropriateness Index (MAI)[3], with a 24% decrease in the inappropriate use of medications among beneficiaries 60 years of age or older.[4]

Missouri Medicaid Pharmacy-Assisted Collaborative Disease Management Program: In July 2003**, t**he state of Missouri undertook a pharmacy-led disease management program for

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[2] Under the Mississippi waiver program, Medicaid pays a flat $20 fee for 15- to 30-minute patient encounters. Under the Iowa and Missouri programs, pharmacists are paid $75 for the patient's initial and annual assessment and $40 for problem follow-up assessments, as well as $25 for preventative assessments. The Minnesota program is paying Minnesota $54 for the first patient encounter and $32 for a limited number of follow-up encounters. The North Carolina program will reimburse those pharmacies that agree to accept locked-in beneficiaries for MTM services at $10 per month per beneficiary.

[3] The MAI employs implicit criteria to judge the appropriateness of medication prescribing. It measures the following key areas of desirable medication use: 1) medication indication, 2) effectiveness, 3) dosage, 4) correct directions, 5) drug-drug interactions, 6) drug-disease interactions, 7) expense, 8) practical directions, 9) therapeutic duplication, and 10) duration. The MAI does not measure adverse indications or patient medication compliance.

[4] *Iowa Medicaid Pharmaceutical Case Management Program, Report of the Program Evaluation,* University of Iowa Colleges of Public Health, Pharmacy, and Medicine, December 2002.

Medicaid beneficiaries with asthma, depression, diabetes, and a history of congestive heart failure, choosing those beneficiaries for participation who were most at risk. Medicaid enrollees with at least one of those diagnoses can be voluntarily enrolled. Once an enrollee candidate is identified, the Department of Medicaid Services recruits the beneficiary's primary care provider and the pharmacist normally used to fill the beneficiary's prescriptions, asking those providers to work in a collaborative mode. After the physician and pharmacist conduct their own assessments, the providers are encouraged to have at least one initial face-to-face meeting. Following that initial provider meeting, disease management is provided through patient face-to-face meetings with one or both providers, depending on the issues to be discussed.

The Missouri program in its first year utilized the services of 318 physicians and 290 pharmacists, focusing on 1,203 high-risk patients with asthma, diabetes, heart failure, depression, and related co-morbidities. At the end of that year, state Medicaid officials estimated that per capita annual program expenditures had been reduced by $6,804 and they projected annualized program savings of $2.4 million.[5] The patients showed a 7.6 percent reduction in health care utilization, including fewer hospitalizations, fewer emergency room visits, lower prescription drug utilization, fewer office visits, and lower per-month expenditures.

Minnesota Medicaid Medication Therapy Management Program: As noted above, the Minnesota legislature in its First Special Session of 2005 enacted legislation requiring the establishment of a Medicaid medication therapy management program. The Minnesota Department of Human Services (DHS) implemented MTM guidelines in April of this year, utilizing the *Core Elements of an MTM Service* model developed jointly and published in April 2005 by NACDS and the American Pharmacists Association (APhA). That model describes the MTM services that can be provided by community pharmacies, and is designed to improve care, enhance communication among patients and providers, improve collaboration among providers, and optimize medication use for improved patient outcomes.

Minnesota Medicaid beneficiaries are eligible for the program if they:
- Are taking four or more prescriptions to treat or prevent two or more chronic medical conditions; or
- Have drug therapy issues identified by DHS that have resulted in, or will likely result in, significant non-drug Medicaid costs.

Maryland P3 Diabetes Disease Management Program: In February 2006, the University of Maryland School of Pharmacy, the Maryland Pharmacists Association, and Maryland Medical Assistance unveiled P3, a disease management program for diabetics living in Maryland's Allegany County. Under the program, trained pharmacists teach diabetic Medicaid beneficiaries and employees of private employers how to use blood glucose monitors correctly, and they provide counseling aimed at helping the diabetic patients better control their disease. The pharmacists meet with participants regularly to review blood sugar readings and discuss the participant's condition, setting goals in collaboration with physicians. The monitor, other diabetes supplies, and diabetes-related medications are free to participants. The employer or the

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[5] *2006 Disease Management Directory & Guidebook*, "Pharmacist-Led DM Delivers Clinical, Financial Dividends, pp. 7-10, and Missouri Medicaid DM Program Shows Positive First-Year Outcomes, pp. 583-84.

Medicaid program pay for the pharmacy visits and any prescription drug co-pays. The Maryland Pharmacy School provides supplemental training to the participating pharmacists.

North Carolina Lock-In Program: The North Carolina Medicaid program implemented, in June 2006, a pharmacy lock-in program for beneficiaries taking more than 11 medications per month. This program reimburses those pharmacies that voluntarily agree to participate in the program for providing MTM services to beneficiaries designated for lock-in. Beneficiaries are locked in to receiving their medications and MTM services from the pharmacy from which they normally receive pharmacy services. The participating pharmacies are to be reimbursed on a per-patient per-month basis. (This program differs from the Virginia Client Medical Management Program which locks-in beneficiaries to primary care physicians or primary pharmacies when there are indications of beneficiary fraud and abuse.)

Pharmacy Coalitions Have Been Working to Create an MTM Model

NACDS is part of a coalition known as the Pharmacy Quality Alliance (PQA) that also includes the Centers for Medicare and Medicaid Services (CMS), the National Community Pharmacists Association (NCPA), and America's Health Insurance Plans (AHIP) and others. One purpose of that alliance is to develop strategies for optimizing patient health outcomes using pharmacy services, for example by helping Medicare Part D enrollees with multiple illnesses understand how to use their medications, thereby improving their compliance with medication treatment regimens and reducing overall health care costs for Medicare enrollees. The strategies produced are likely to build on the *Core Elements of an MTM Service* model.

MTM is most effective when conducted face-to-face in interactions that provide the pharmacist with the optimal opportunity to observe signs of and visual cues to the patient's health problems, including adverse reactions to medications and problematic interactions between medications. The pharmacist's observations produce early detection of medication-related problems that can reduce emergency room visits, hospitalizations, and abuse of medications.

Proposal 2: Expand Use of E-Prescribing and Related Technologies

As the federal Medicaid Commission has correctly observed, health information technology can be used to (1) monitor and improve safety and quality, (2) control costs, (3) simplify program administration, (4) improve data collection, and (5) improve patient coordination among multiple providers. In summary recommendations now under consideration, the Commission has suggested that federal incentives should be provided to encourage the states to implement e-prescribing and other e-technologies.

E-prescribing is the use of electronic systems to generate prescriptions and transmit prescription information between prescribers, pharmacists, and payors such as Medicaid programs (or their designated fiscal intermediaries). The Medicare Modernization Act and the regulations adopted under that act require that prescribers and dispensing pharmacies comply with federal e-prescribing standards for drugs covered under Medicare Part D that are prescribed to Part D-eligible individuals. Because these mandated e-standards already apply to the prescriptions

dispensed to dual eligibles under Part D, considerations of administrative efficiency would seem to dictate that they be extended to apply equally to non-dual Medicaid beneficiaries.

E-technology is a term sometimes used to describe systems that offer additional tools to make prescribing safer and more efficient. Basic e-prescribing systems typically provide physicians with a drug database for prescribing, check prescriptions against a formulary, and screen for drug-drug interactions with other drugs prescribed using the system. More extensive e-technology may include patient profiles that associate diagnoses with prescriptions, screen for drug allergies or drug-disease warnings, and offer additional drug reference capabilities.

These automated systems can provide several benefits to Medicaid programs:
- Increased accuracy and patient safety due to computer generation of legible, consistently formatted prescriptions, and screening for potential interactions;
- More efficient methods for monitoring patient history, and the reduction or elimination of poly pharmacy, fraud, and abuse;
- Better formulary compliance, with checks performed at the point of prescribing;
- More efficient communication with pharmacies, with a reduced need for calls to physicians to clarify information from handwritten or telephoned prescriptions; and
- Improved patient satisfaction due to the rapid filling of prescriptions, with fewer errors.

In 2004, Florida Medicaid contracted with a private company to provide handheld, wireless devices to 1,000 high-volume prescribers. The devices provide the Medicaid PDL, 60-day patient-specific prescription histories, and drug utilization reports (interaction reports, etc.). An expansion of the program that began in January 2005 eventually provided devices to a total of 3,000 prescribers and expanded the patient prescription histories to 100 days. In the program's first year, Florida Medicaid observed an absolute reduction of four percent in significant drug interactions, with cost savings of about $700 per month for each physician enrolled in the program (about $8.4 million in savings annually). By March 2006, the Florida Agency for Health Care Administration was reporting savings of $825 per physician per month.

There are over 19,700 non-federal practicing physicians in Virginia. If just 10 percent of those physicians were to utilize e-prescribing technology similar to that used in Florida, Virginia could see savings of $19.5 million to $35.5 million.

Conclusion

NACDS believes that the adoption of these specific approaches to Medicaid revitalization – greater use of medication therapy management and an expansion of pharmacy-assisted collaborative disease management, and e-prescribing technology and related e-technology systems – would mean better patient outcomes for Virginia's Medical Assistance population and significant savings for the Commonwealth's Medicaid program. We strongly encourage the Medicaid Revitalization Committee to include these measures in any Medicaid reform package.

Thank you for the opportunity to comment.